Saint Louis University Journal of Health Law & Policy

Volume 1
Issue 1 *Medicare After the Medicare Modernization Act*

Article 11

2007

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MEDICARE AFTER THE MEDICARE MODERNIZATION ACT

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By adapting the payment structure of America's private health insurance, Medicare, from its inception, has provided access to a unique healthcare system for elderly and disabled Americans. For several decades, Congress has also used Medicare as a policy tool to contain rising healthcare costs.[1] The Medicare Modernization Act (MMA)[2] is the latest and, perhaps, the most significant of these cost-containment efforts.

In order to understand the role Medicare will play in containing future healthcare costs, it helps to understand how difficult it is to influence behavior in the delivery system. The United States has always enjoyed a healthcare system different from those of all other countries. Therefore, we cannot simply adapt another country's older, tried-and-true model for our own cost-containment policy.

Most Americans choose a job, a health insurance plan, and a doctor; and the insurance and doctor make the rest of the decisions. Accordingly, the doctor-patient relationship is dominated by the physician's autonomy and is reinforced by the influence physician professional societies have on economics, clinical improvement, and public finance policy.[3]

For many years, most insurance plans have simply paid for service volume, rather than value, and most physicians have liked it that way.[4] Medicare was no different. Even more problematic is the fact that Medicare (with one brief exception in the short-lived Medicare Catastrophic Act of

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1. *See* BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 517, 744 5th ed. 2004) (discussing how public-health program cost-control efforts have focused on limiting prices paid for services or the use of managed care and that, in response to increasing costs, the ongoing Medicare-reform debate focuses on how the program should pay for healthcare services).

2. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (codified in scattered sections of 42 U.S.C. and 26 U.S.C.).

3. *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 217 (1982).

4. *See Id.* at 325-26 (comparing direct-service plans (volume) with service-benefits plans (value), commenting on a service-benefit plan that "plunged into crisis" when it attempted to review physicians' decisions about hospitalization, and asserting that direct-service plans create an inherent "environment of constraints, such as a fixed supply of hospital beds," which physicians can take for granted in "day-to-day medical decision making").

1988) [5] has never protected beneficiaries from financial catastrophe. What results is a market dysfunction that is not present in any other part of the U.S. economy. (Education is the only sector that comes close).

The standard of quality in healthcare is "the doctors know best." Third party employers and insurers indemnify the costs of healthcare. Accountability is based on what the doctors do, not on how well they perform. More is always better; the higher the price, the greater the presumed value; and brand name medicine is the vogue.

While this insurance policy has given us access to an explosion of medical technology, our population's health status has generally declined and the incidence of chronic illness has rapidly risen.[6] Medicare and other public funding sources invest billions of dollars per year in new discoveries (plus a few million in evaluating them) and ensuring older Americans have the ability to make informed decisions as they enter lives of increased dysfunction. Yet, the average life expectancy in the United States is no better than the average life expectancy of a developed nation; and the healthy life expectancy (age sixty-seven for males and age seventy-one for females) is among the lowest.[7]

Medical care prices reflect production costs, as well as inefficiencies, the cost of treating the uninsured and underinsured, geographic location, medical education, and clinical research.[8] We, as consumers of this care, are only responsible for choosing the doctor, not the care, because the information needed to make decisions about medical care is exclusively in the doctors' hands. As a result, we are unhealthy people with very unhealthy expectations, and none of us are held appropriately accountable or individually responsible.

Healthcare costs per capita in the United States are twice what they are in any other country[9] and are crowding out spending on every other

5. *See* Thomas Rice et al., *The Medicare Catastrophic Coverage Act: A Post-Mortem*, 9 HEALTH AFF. 75, 76-78 (1990) (noting that less than two years after enacting the Medicare Catastrophic Coverage Act, Congress retracted it because of "negative public reaction").

6. *See* Gary Rotstein, *Boomer Health Decline Reported: Are They Less Well than Earlier Group? Or is it Imagined?*, PITT. POST-GAZETTE, Mar. 18, 2007, at A1, *at* www.post-gazette.com/pg/07077/770461-114.stm# (last visited Jan. 1, 2008).

7. *See* WORLD HEALTH ORG., HEALTH STATUS: MORTALITY 28 (2006), *available at* www.who.int/whosis/whostat2006_mortality.pdf (last visited Oct. 23, 2007).

8. *See Health Care and the Budget–Issues and Challenges for Reform, Hearing Before the S. Comm. on the Budget*, 110th Cong. 4-9 (2007) (statement of Peter R. Orszag, Director, Congressional Budget Office) (outlining several factors contributing to medical costs, including new medical therapies and technology, geography, insurance factors, and quantity of healthcare services).

9. *See* THE HENRY J. KAISER FAMILY FOUND., SNAPSHOT: HEALTH CARE SPENDING IN THE UNITED STATES AND OECD COUNTRIES (Jan. 2007), *at* http://kff.org/insurance/snapshot/chcm010307oth.cfm (last visited Oct. 23, 2007) (noting that U.S. healthcare spending per

common good, except homeland security and international wars. How have we managed to do this to ourselves? Sociologist Paul Starr answers this question in his books *The Social Transformation of American Medicine* and *The Logic of Health Reform*, concluding that "the American health care system has developed under the shaping influence of incentives for private decision makers to expand and intensify medical services."[10]

What will we get for the $2.3 trillion spent on healthcare[11] in the United States this year? We will get more, and presumably better, drugs, devices, diagnostics, and specialty facilities. Patient safety, however, is unlikely to improve. The patient safety record in the United States has not changed much since the IOM reported 98,000 patients needlessly die each year in America's hospitals.[12] The employee safety record is just as shameful. Dr. Jack Wennberg and his Dartmouth colleagues have made us aware of the clinical outcome disparities in medical practice across the country.[13] They argue that if Medicare paid all hospitals and doctors what it pays providers in the lowest-cost regions of the country, Medicare could save almost 30% of what it spends in one year on health benefits under the traditional program.[14] (Total Medicare spending was projected to reach $429.7 billion in 2007.)[15]

In my community, at last count, there were over 400 allied or ancillary health professional guilds operating in much the same way and to the same end as guilds were in Adam Smith's day. Yet, both private plans and public programs continue to reward those who refuse to improve healthcare at the financial expense of practitioners and communities that continually seek to improve what they do and how they do it. Efficiency, effectiveness, productivity, and perfection are words commonly used when discussing healthcare but rarely put into practice. Health professionals make little use

capita is "at least 24% higher than the next highest spending countries, and over 90% higher than . . . global competitors").

10. PAUL STARR, THE LOGIC OF HEALTH CARE REFORM: WHY AND HOW THE PRESIDENT'S PLAN WILL WORK 23 (Penguin Books 1994) (1992).

11. John A. Poisal et al., *Health Spending Projections Through 2016: Modest Changes Obscure Part D's Impact*, 2007 HEALTH AFF. (WEB EXCL.) w242, w243.

12. INSTITUTE OF MEDICINE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1 (Linda T. Kohn et al. eds., 1999) (using data from a study conducted in New York).

13. *See generally* John E. Wennberg et al., *Geography and the Debate over Medicare Reform*, 2002 HEALTH AFF. (WEB EXCL.) W96, W96 (discussing how Medicare spending across the nation varies with no obvious pattern).

14. *See id.* at W104 (using 1996 numbers to project that $40 billion would have been saved if "spending levels in the lowest [spending region] were realized in all higher [spending] regions").

15. CTRS. FOR MEDICARE & MEDICAID SERVS., CMS PROGRAMS AND CMS FINANCIAL DATA: 2007 WALLET CARD, *available at* www.cms.hhs.gov/CapMarketUpdates/Downloads/2007WalletCard.pdf (last visited Jan. 2, 2008).

of technology to gather and translate information and then apply what we already know, or should know, to what we need to know right now.

Is it now clear why it is hard to "modernize" Medicare as President Bush and the Republicans in Congress claimed to do by passing the MMA in 2003? The United States faces a *leadership* problem, not a *legislative* problem. The issue is not with cost-containment; we need to change the economics of a dysfunctional system that rewards medical professionals in positions of leadership for playing the "competition" game by rules they may dislike, but have adapted to, rather than for providing leadership to change the system. The failure to reward leaders of reform probably stems from the fact that costs to healthcare consumers are income to healthcare professionals.

I once heard someone say that human nature inclines us to accept for our own reality influences on our future that are beyond our control. Accepting such influences as reality is exactly what every hospital and many clinical organizations are doing.

How long will the MMA last? The politics of health policy reform help answer that question. Republicans and Democrats have long held different ideological views on national health policy. Democrats have been egalitarian: if it is good for some, then it is good for everyone. They have brought Americans the wonders of medical innovation and its accompanying doctors and hospitals. As champions of universal access and coverage through public and private insurance, Democrats created numerous public programs under the Social Security Act to help those disadvantaged by age, sex, geography, economic condition, and health condition.

Republicans, traditionally a congressional minority, teamed with more conservative Democrats from the South, whose long service once made them important committee chairs, to slow down the liberal tendencies of northern Democrats. By the early 1970s, the steam of the universal coverage movement was slowly dissipating. The sand in the gears was the program costs.[16] Dealing with rapidly increasing costs became everyone's responsibility. (Costs increased from $75 billion in 1970 to $190 billion in 1978,[17] the year I was elected to the Senate.) Therefore, Democrats and Republicans, from both the North and South, found it necessary to reach a consensus in committees such as Senate Finance, House Ways and Means, and House Energy and Commerce.

16. *See* STARR, *supra* note 3, at 380 (noting that, beginning in 1975, aspirations such as national health insurance were thrown aside in the midst of inflation and doubts about medical care).

17. Stephen H. Lone & W. Pete Welch, *Are We Containing Costs or Pushing on a Balloon?*, 7 HEALTH AFF. 113, 114 (1988).

From the mid-1970s to the end of the 1980s, partisanship was minimal in Congress's enactment of some radical healthcare cost-containment strategies.[18] In the 1970s, Congress's strategy was supply regulation.[19] For the public sector, Congress chose to use Certificate of Need, Health Systems Agencies, and Community Health Planning.[20] This approach did not work. The private sector established Health Maintenance Organizations (HMOs), which were slow getting off the ground because organized medicine opposed them.[21] President Carter proposed putting America's hospitals on annual budgets, similar to what is still done in Maryland today.[22] Together, Republicans and Democrats narrowly defeated this proposal and, under President Reagan, turned to price regulation through prospective pricing programs like diagnosis related groups for hospitals and resource based relative value pay with volume performance standards to protect against excess utilization for doctors.[23] Congress began nurturing HMOs with Medicare risk contracts to provide Medicare-covered services for 95% of the cost of Medicare fee-for-service.[24]

By 1990 Americans were consuming $664.5 billion a year in medical services,[25] and HMOs were beginning to merge with each other into larger and larger national managed care organizations. State Blue Cross and Blue Shield plans began converting from non-profit to for-profit status and merging with each other into giant plans such as WellPoint and Anthem, which are now one company.[26] National employers especially loved to hire

18. *See generally* Miriam J. Laugesen & Thomas Rice, *Is the Doctor in? The Evolving Role of Organized Medicine in Health Policy*, 28 J. HEALTH POL. POL'Y & L. 289, 299-301 (2003) (discussing the internal changes within Congress that transformed payment to the medical profession).

19. *See* FURROW ET AL., *supra* note 1, at 518.

20. *Id.* at 517-18.

21. *See id.* at 567.

22. *See* John K. Iglehart, *Hospitals, Public Policy, and the Future: An Interview with John Alexander McMahon*, 3 HEALTH AFF. 20, 21, 24-25 (1984) (discussing the American Hospital Association's (AHA's) tolerance of state hospital regulation, such as that enacted in Maryland, but noting that the AHA's block against similar national regulation, i.e., "the simplistic kind of solution offered by President Carter," was a major achievement).

23. *See* Laugesen & Rice, *supra* note 18, at 299-303.

24. Deborah A. Ellwood, *Medicare Risk Contracting: Promise and Problems*, 5 HEALTH AFF. 183, 183 (1986).

25. *See* Press Release, U.S. Dep't of Health & Human Servs., Study – Health Expenditures (Jan. 29, 1993), *at* www.hhs.gov/news/press/pre1995pres/930129.txt (last visited Jan. 2, 2008) (citing Health Care Financing Administration's statistics that health expenditures increased 11.4% from 1990 to 1991).

26. *See* Mark A. Hall & Christopher J. Conover, *For-Profit Conversion of Blue Cross Plans: Public Benefit or Public Harm?*, 27 ANN. REV. PUB. HEALTH 443, 444 (2006). Blue plans in fourteen states have converted to for-profit status and most of those plans merged into WellPoint and Anthem. *Id.* WellPoint and Anthem merged in 2004. *Id.*

these managed care organizations to reduce employee access to "unneeded" medical services.

In the early 1990s, the conversion to managed care seemed to contain costs. Annual cost increase, as high as 17% in 1989, fell to zero in 1996.[27] However, patients soon joined doctors in objecting to limitations on access to needed services, and healthcare costs again rose into double digits annually. By 2000, healthcare spending was approximately $1.3 trillion and has not changed much since then.[28]

Although today's healthcare costs remain consistent with 2000 costs, the politics and the ideology of prevailing health policy have changed. As Americans became more centrist in the early part of the 1990s, Republicans saw a chance to gain majority status in Congress. "Economically conservative and socially liberal" Republicans began to win elections. When Arkansas Governor Bill Clinton was elected president in 1992, he vowed to reform healthcare, bring down its costs, and ensure that every American could afford health insurance. He gave his wife the task of accomplishing this reform.[29] By bringing together almost every reform idea proposed from the previous twenty years, Hillary Clinton created the Health Security Act (HSA).[30] Unfortunately, the legislation was so complicated, comprehensive, and ignorant of political realities that even the group of "mainstream" Republicans who had been steering much of the bi-partisan Medicare and Medicaid reform legislation since the early 1980s could not support it.[31]

More ideologically conservative Republicans saw their chance and answered Clinton by saying that doing nothing would be better than passing the HSA.[32] But instead of just doing nothing, Republicans recognized the centrist trend in the country and were able to ride their "Contract with America," a contrast to the "socialist medicine" the HSA represented, to a

27. THOMAS A. SCULLY & LAMBERT VAN DER WALDE, CTRS. FOR MEDICARE & MEDICAID SERVS., HEALTH CARE INDUSTRY MARKET UPDATE: MANAGED CARE 2 fig.2 (Nov. 28, 2001), *available at* www.cms.hhs.gov/CapMarketUpdates/Downloads/hcimu112801.pdf (last visited Jan. 2, 2008).

28. Brian Vastag, *IOM Public Health Report Urges Massive Change*, 288 JAMA 2807, 2807 (2002).

29. *See* Julie Rovner, *Congress and Health Care Reform 1993-1994*, *in* INTENSIVE CARE: HOW CONGRESS SHAPES HEALTH POLICY 184-88 (Thomas E. Mann & Norman J. Ornstein eds., 1995) (discussing the Clinton Plan and Hillary Clinton's involvement).

30. *See id.* at 196.

31. *See* David F. Durenberger & Susan Bartlett Foote, *Changing the Way We Think About Medical Technology Policy*, 72 ANNALS THORAC. SURG. 1113, 1113 (2001) (discussing the Clinton policy's lack of focus on the public perception of the healthcare problem and the resulting loss of Republican support).

32. *See generally* Theda Skocpol, *The Rise and Resounding Demise of the Clinton Plan*, 14 HEALTH AFF. 66 (1995).

congressional majority in 1995.[33] Republicans continued to reject bi-partisan reform efforts because the proposals did not comply with their own "medical markets" ideology.

When George W. Bush was elected in 2000, he aimed for bi-partisan domestic policy. Examples of such policies are the No Child Left Behind Act[34] and Immediate Helping Hand, a program to provide low-cost access to prescription drugs for low-income, medically needy, elderly, and disabled Americans through federal government support for state Medicaid programs.[35]

In a few years, history, not this summary, will tell us exactly how the President's Helping Hand program changed health insurance ideology. There is no doubt, however, that it represents a gigantic change. By a one-vote margin secured after three precedent-setting hours of voting in the House of Representatives, Republicans passed the first partisan change in Medicare and national health policy in decades, thereby setting an entirely new course for our health system.[36] Spurred on by the rejection of supply and price regulation as natural cost-containment strategies, Republicans proposed "consumer-driven healthcare,"[37] armed consumers with high-deductible private health insurance plans, and turned them loose on the healthcare system. They bought Senate votes for their scheme when AARP, a giant lobbyist for senior-citizen insurance, endorsed Medicare Part D as a method to create an affordable prescription drug program for every Medicare beneficiary by using private insurance and pharmacy benefit management (PBM) pricing and purchasing.[38] The apparent success of this approach was assured when President Bush appointed Dr. Mark McClellan, formerly of the Food and Drug Administration, to direct MMA implementation at the Centers for Medicare and Medicaid Services (CMS).

33. Russell L. Riley, *Party Government and the Contract with America*, 28 PS: POL. SCI. & POL. 703, 704 (1995) (discussing the Republicans' Contract with America, "to which an overwhelming majority of the party's congressional candidates publicly pledged allegiance").

34. No Child Left Behind Act of 2001, Pub. L. No. 107-110, 115 Stat. 1425 (2002).

35. *See* OFFICE OF MGMT. & BUDGET, A BLUEPRINT FOR NEW BEGINNINGS: A RESPONSIBLE BUDGET FOR AMERICA'S PRIORITIES 113 (2002), *available at* www.whitehouse.gov/news/usbudget/blueprint/blueprint.pdf (last visited Jan. 20, 2008).

36. *See* Ted Barrett, *Kennedy Vows Filibuster of Medicare Bill*, cnn.com, Nov. 23, 2003, *at* http://edition.cnn.com/2003/ALLPOLITICS/11/22/elec04.medicare/ (last visited Jan. 2, 2008).

37. *See* Ralf Boscheck, *Market-Testing Healthcare: Managed Care, Market Evolution and the Search for Regulatory Principles*, 41 INTERECONOMICS 328, 328 (2006) (noting that President Bush called the transformation of U.S. managed care "consumer-driven healthcare" in his 2006 State of the Union address).

38. *See* Jonathan Weisman, *Means Test Sought for Medicare Drug Plan*, WASH. POST, Oct. 5, 2007, at A1 (noting that AARP's endorsement of Part D was "particularly pivotal in securing its narrow passage").

But look behind the curtain—nothing has changed since 1970. During President Bush's years in office, health insurance premiums have grown by almost 80%, while the income of the average American family has grown by only 19%.[39] Each year the number of Americans who drop insurance coverage increases[40] despite the availability of low-premium, high-deductible catastrophic insurance plans. So far there is no evidence that the consumer-driven approach is working; nor is there any evidence that privatization of the Medicare program through Medicare Advantage and private fee-for-service plans has impacted costs. One reason is that Republicans are spending a lot of Medicare money to make private health insurance available to beneficiaries, and care through private Medicare plans is not available for 95% of traditional fee-for-service costs, like it was in the 1980s. Instead, private insurance plans for Medicare beneficiaries now cost between 112% and 119%, on average, of what traditional Medicare costs per beneficiary.[41]

This year the Democrats are back in control of both Houses of Congress, but Republicans have a veto-sustaining margin in the Senate and, therefore, stymie Democratic health policy leaders. In the 2008 primary campaign for President, most Republicans are supporting the ideology of the MMA, advocating a greater use of tax-deductible insurance for individual plan premiums and a national insurance market without national rules for insurance companies, and backing employers out of the individual employee health insurance coverage decision. This position is a contrast to that of the Democratic candidates who put priority on achieving universal coverage. Most Democrats also support efforts to contain costs through the financing and reimbursement system and greater emphasis on quality, value, and comparative effectiveness of technology.

The partisan divide continues in part because many American doctors and all private insurance plans (except HMOs like Kaiser Permanente) like the "business as usual" approach inherent in Republican notions of medical markets. Republicans do support efforts to achieve greater price transparency, utilization of health information technology and electronic

39. *See* THE HENRY J. KAISER FAMILY FOUND., TRENDS IN HEALTH CARE COSTS AND SPENDING 2 (Sept. 2007), *available at* http://kff.org/insurance/upload/7692.pdf (last visited Jan. 2, 2008) ("Between 2002 and 2007, the cumulative growth in health insurance premiums was 78%, compared with cumulative inflation of 17% and cumulative wage growth of 19%.").

40. *See generally* John Holahan & Allison Cook, *Changes in Economic Conditions and Health Insurance Coverage, 2000-2004*, 2005 HEALTH AFF. (WEB EXCL.) W5-498 (discussing the growing number of uninsured adults and the factors that may contribute to this trend).

41. *See Medicare Advantage Private Fee-for-Service Plans: Hearing Before the Subcomm. on Health of the H. Comm. on Ways and Means*, 110th Cong. (2007) (statement of Patricia Neuman, Vice President, The Henry J. Kaiser Family Foundation, Director, Medicare Policy Project).

medical records, direct-to-consumer marketing of drugs and medical devices, and any effort to end "socialized medicine as we've known it," including any requirements that employers provide or pay for health insurance for employees.[42]

What does the future hold? By January of 2009, the United States will probably have a Democratic President and a Democratic Congress. (Although, this likely outcome would have more to do with the Iraq and Afghanistan wars and Republican congressional ethics than with the health policy debate.) Health policies will continue to focus on state and local government efforts to improve cost containment, universal coverage, and quality. While many of these efforts, unlike the current debates in Washington, are fairly bipartisan, they will have limited success for two reasons. First, meaningful universal coverage cannot be provided without either new taxes or large amounts of federal dollars, and new taxes are not a possibility. While federal contributions to state programs are increasing, federal legislators are also attaching more directives to this spending, thus diminishing the creativity of state coverage efforts. Second, value-based cost containment strategies depend on the cooperation of medical professionals. There are well-known parts of the country where localized strategies will work when financially rewarded, but many more parts of the country where these strategies either will not work or are substantially less likely to work. If federal policy had a way to increase both financial rewards for improved performance and financial risk for low performers, a different outcome could be reached.

Furthermore, the election of a new president will play a role at the national level, as a new president has a great deal of leverage in his/her first years in office. Senator Clinton knows better than most that how that power is used will determine the course of the Presidency. Of both parties' candidates, she knows health policy the best, has the most experience, and has the least to learn. Whoever is elected will likely take the advice she is currently giving: to focus, first, on enhancing value through financing changes in public programs like Medicare and Medicaid; second, to use private health plans where they can produce a better result and pay them for performance, just as most policymakers suggest we should be paying providers for performance; third, to launch an investment strategy to produce health information (and expand the technology to make it available

42. *See* REPUBLICAN NAT'L COMM., 2004 REPUBLICAN PARTY PLATFORM: A SAFER WORLD AND A MORE HOPEFUL AMERICA (Aug. 26, 2004), *available at* www.gop.com/media/2004 platform.pdf (last visited Jan. 2, 2008).

to all in a timely manner); and, finally, to reduce costs by reducing unnecessary care.[43]

I remain an optimist about the future of healthcare in this country. Presidential leadership in focusing the Medicare program on genuine payment and delivery reform is very important, but it is not as important as the health professional leadership that lies dormant in communities of physicians and other professions across America. I have heard Walter McClure, a well-respected health economist, say many times that American medicine is remarkably inventive. When pointed in the right direction it will steadily raise effectiveness and reduce cost, just as most other productive industries do today.

43. For an explanation of Senator Clinton's proposed health plan, see Hillary for President, American Health Choices Plan, www.hillaryclinton.com/feature/healthcareplan (last visited Jan. 16, 2008).